COMMUNITY MEDICAL CENTERS

Medical Record#:____________________________________
Patient Name (print): ____________________________________ Date of Birth:______________
Address (Street/City/State/Zip):____
Telephone: ____________________________________SSN (last 4 digits): _________________

1. **I hereby authorize that my protected health information be released from (select all facilities that apply):**
   - ☐ Community Regional Medical Center, 2823 Fresno Street, Fresno CA 93721
   - ☐ Clovis Community Medical Center, 2755 Herndon Avenue, Clovis CA 93611
   - ☐ Fresno Heart & Surgical Hospital, 15 E. Audubon Drive, Fresno CA 93720, includes Advanced Diagnostic Testing Center (ADTC)
   - ☐ Community Behavioral Health Center, 7171 N. Cedar Avenue, Fresno CA 93720
   - ☐ Community Cancer Institute, 785 North Medical Center Drive West, Clovis CA 93611
   - ☐ Community Subacute Transitional Care Center, 3003 N. Mariposa, Fresno CA 93703
   - ☐ Other (Please Specify): ____
2. **I hereby authorize the following persons or entities to receive my health information:**
   Name of Person/Entity: ____
   Address/City/State/Zip: ____
   Telephone: ____________________________ Fax: ____________________________
3. **Information to be Disclosed (tell us what information you need):**
   Information to be disclosed for the following date range _____________to ______________
   - ☐ Physician Report(s) and Test Result(s)
   - ☐ Radiology Report(s) Only
   - ☐ Radiology Image(s) – specify: ☐ X-Ray ☐ Ultrasound ☐ CT Scan ☐ MRI ☐ Mammography
   - ☐ Laboratory Test(s) Only
   - ☐ Complete Medical Record (all pages), excludes Radiology Images
   - ☐ Billing Records
   - ☐ Other (specify): ____
4. **Sensitive Information (WILL NOT BE RELEASED unless you initial below):**
   __________ Release Drug and Alcohol abuse treatment records
   __________ Release Mental Health/Psychiatric treatment records
   __________ Release HIV Test Results
   __________ Release Genetic Test Results
   __________ Release Abortion Care-Related records
   __________ Release Contraception records
   __________ Release Gender-Affirming records

Note: A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

Health Information Management

Authorization to Release Protected Health Information

OFFICE USE ONLY Identification verified by (name): __________________________________
Verified by (method): ☐ Photo ID ☐ Matching Signature
☐ Other: ____________________________________

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5. **Purpose of Requested Use or Disclosure (tell us how you will use the records):**

☐ Continuation of Medical Care ☐ Personal Use ☐ Insurance

☐ Other (please list): ______________________________

Limitations, if any: ______________________________

____

6. **Requested Format (ONLY check one):**

☐ MyChart / Online Portal ☐ Compact Disc (CD) ☐ USB Flash Drive ☐ Paper Copy

☐ Email (unencrypted, note – if you request information to be sent via email unencrypted there is an increased risk information could be read by an unauthorized third party), provide email address:

____

☐ Other (must be agreed upon by the patient and provider): ______________________________

7. **Method of Release for paper copy or CD / USB Flash Drive (ONLY check one):**

☐ Mail ☐ Fax (paper only) ☐ Pick-Up (if applicable)

8. **Expiration:**

This authorization shall become effective immediately and shall remain in effect for (1) year from the date signed unless a different date is specified here: ____________________ (initial) ________________

9. **Your Rights:**

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility benefits.
- I may inspect or obtain a copy of the health information I am being asked to allow the use or disclosure of.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I revoke this Authorization for Release of Protected Health Information

  Date of Revocation: ________________ Signature: ______________________________
- I have a right to receive a copy of this authorization.
- ☐ If this box is checked, Community Medical Centers will receive compensation for the use or disclosure of my health information.

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10. Signature (as required by law):

_______________ _______________________________________

Date / Time *Patient / Representative* Signature*

If signed by other than patient, print name and indicate relationship to patient.

_______________ _______________________________________

Relationship *Print Name*

****Authorized legal representative signing for the patient must provide copies of the legal documents describing the personal representative's assignment of this authority.***

_______________ _______________________________________

Date / Time *Witness Signature # 1 / Print Name / Title*

_______________ _______________________________________

Date / Time *Witness Signature # 2 / Print Name / Title*

(Witness Signature #2 required if patient marks with an "X".)

11. Interpreter Signature if applicable:

I have accurately and completely read the above document to *(patient or legal representative's name)* ____in *(language)* ___________________, the patient or legal representative's primary language. The patient or legal representative understood all of the terms and conditions and acknowledged their agreement by signing the document in my presence.

Interpretation provided: ☐ In Person ☐ Remote

Interpreter Signature / Agency:

_______________ _______________________________________

Date / Time *Interpreter Signature / Print Name / Title*